

December 1, 2016

Kevin Counihan
Director & Marketplace Chief Executive Officer
Center for Consumer and Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Draft 2018 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Mr. Counihan:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – of which, approximately 100 offer health plans – and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) draft 2018 Letter to Issuers, which provides technical and operational guidance to those wishing to offer qualified health plans (QHPs) in the federally-facilitated marketplaces (FFMs). The draft Letter to Issuers also reflects additional guidance on standards included in CMS’s proposed rule, titled “HHS Notice of Benefit and Payment Parameters (NBPP) for 2018.” The AHA [previously commented](#) on this proposed rule and focused on a number of issues, including payment parameters, including risk adjustment; special enrollment periods; and acceptance of third-party payments by QHPs. Our comments on the draft Letter to Issuers will focus more narrowly on the auto-reenrollment crosswalk, network adequacy and essential community providers.

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

Section 3. Plan ID Crosswalk

Consumers are best served when they have continuity among their care team. Unless they have specifically chosen to change provider networks, we believe it is critically important that provider networks be taken into account when auto-reenrolling consumers whose current QHP is no longer available. However, we appreciate that CMS may not have sufficient information readily available to compare provider networks for purposes of auto-reenrollment. In previous years, CMS has worked with states on final auto-reenrollment decisions, and the process has generally included consultation with relevant stakeholders, including providers and plans. This



process has been instrumental in ensuring continuity of care and minimizing disruption and confusion for enrollees. We strongly encourage CMS to develop a standardized process that includes stakeholder consultation. Specifically, we ask that CMS develop a timeline for releasing the initial and final cross-walk lists and a process for accepting feedback from stakeholders.

CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS

Section 3. Network Adequacy Standard (iii) Out-of-Network Cost Sharing for In-Network Settings

As we stated in our comments to CMS on the proposed Notice of Benefit and Payment Parameters for 2018, we support the agency's efforts to further protect enrollees from surprise bills as a result of receiving care from an out-of-network specialist at an in-network setting. However, we remain concerned that CMS's proposals fall short. Specifically, they do not go far enough to address financial protections for consumers facing unexpected medical bills resulting from out-of-network providers at in-network facilities. We continue to recommend that CMS look to the National Association of Insurance Commissioners' (NAIC) Model Act #74, which offers the consumer greater financial protections from unexpected bills through a structured mediation process between the health plan and the out-of-network provider, and apply a consistent policy both inside and outside of the marketplaces.

Section 3. Network Adequacy Standard (iv) Network Transparency

The draft letter to issuers further elaborates on CMS's proposal to identify "integrated delivery systems" as part of the network breadth indicator. We agree with CMS's consideration of additional definitions of "integrated delivery system" beyond what is currently used as the alternate essential community provider (ECP) standard. However, we are concerned that the proposed set of additional definitions may be overly broad and not fully capture the critical care coordination function across the entire continuum of care offered by integrated delivery systems. We encourage CMS to further evaluate whether the proposed definitions – if adopted in full – allow consumers to assess meaningful differences among plans.

Section 4. Essential Community Providers Standard (i) Evaluation of Network Adequacy with respect to all ECPs

We are concerned about CMS's proposal to eliminate the option for issuers to write in ECPs not included in the non-exhaustive list for 2018. Our experience has been that many eligible providers are at risk for being left off the list due to significant confusion about whether they need to petition to be included each year, and whether the agency will identify them from existing lists or carry them over from prior years. The write-in option for issuers is a critical fail-safe for those providers inadvertently left off the list in a given year. We urge CMS to continue to allow write-ins but allow enough time in the process for the agency to incorporate such additions into the denominator for any ECP calculations.

Section 6. Patient Safety Standards for QHP Issuers

We urge CMS to clarify that it expects issuers to accept agreements or attestations to participate in Hospital Improvement Innovation Networks (HIINs) as evidence of meeting the patient safety standards. The AHA appreciates the thoughtful approach and flexibility for achieving compliance with the patient safety standards that CMS adopted in the 2017 Payment Notice. As CMS indicates in the draft 2018 Letter to Issuers, hospital participation, attestation or agreements to participate in Hospital Engagement Networks (HEN) is one way to demonstrate that issuers and hospitals are meeting the standards. We agree that HEN projects should qualify but note that the structure and name of this CMS-coordinated initiative have changed. Participating hospitals now have agreements with HIINs rather than HENs, although the HIIN work still encompasses the criteria of implementing evidence-based initiatives to improve health care quality through the collection, management and analysis of patient safety events that reduces all-cause preventable harm, prevents hospital readmission or improves care coordination. Further, confusion exists because the final language of the 2017 Notice of Benefit and Payment Parameters indicates, but does not definitively state, that issuers must accept HEN/HIIN participation attestations as meeting the reasonable exception criteria. If CMS has designed the HIIN program in such a way that participation should qualify to meet these patient safety standards, then the agency should clarify that issuers cannot reject it.

Thank you for the opportunity to provide input. Please contact me if you have questions, or feel free to have your team contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development